State of Washington

2018-11696

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND I Day	·	ISENTI TOATION NOMBER.	A. BUILDING	·	1	
007470		B. WING		3	C 10/01/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
NAVOS		2600 SOL	JTHWEST H	OLDEN		
NAVOS		SEATTLE	, WA 98126			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
L 000	L 000 INITIAL COMMENTS		L 000			
	The Washington St (DOH) in accordance Administrative Code Psychiatric Hospital safety investigation Onsite dates: 10/01 Examination/Case of Intake number: 843 The investigation we Surveyor #27347	/2018 number: 2018-11696 882		1. A written PLAN OF CORRECT required for each deficiency listed Statement of Deficiencies. 2. EACH plan of correction staten must include the following:  * The regulation number and/or the number;  * HOW the deficiency will be correction;  * WHO is responsible for making correction;  * WHAT will be done to prevent reoccurrence and how you will make continued compliance; and  * WHEN the correction will be cordinated within 10 calendar days to date you receive the Statement of Deficiencies. PLAN OF CORRECTION returned within 10 calendar days to date you receive the Statement of Deficiencies. PLAN OF CORRECTION returned within 10 calendar days to date you receive the Statement of Deficiencies. PLAN OF CORRECTION returned within 10 calendar days to date you receive the Statement of Deficiencies. PLAN OF CORRECTION returned within 10 calendar days to date you receive the Statement of Deficiencies. PLAN OF CORRECTION returned within 10 calendar days to date you receive the Statement of Deficiencies. PLAN OF CORRECTION returned within 10 calendar days to date you receive the Statement of Deficiencies. PLAN OF CORRECTION returned within 10 calendar days to date you receive the Statement of Deficiencies. PLAN OF CORRECTION returned within 10 calendar days to date you receive the Statement of Deficiencies. PLAN OF CORRECTION returned within 10 calendar days to date you receive the Statement of Deficiencies. PLAN OF CORRECTION returned within 10 calendar days to date you receive the Statement of Deficiencies are days to day to day the days to day the days to day to day the day the day the day to day the day to day the day the day the day	on the nent ne tag ected; the onitor for mpleted, must be from the formal tative's lage of	
L1110		L WORK SERVICES	L1110	,		10/26/18
State Form	the attending proferincluding: (d) Social coordinated and sul worker with experie psychiatric patients (i) Reviewing social (ii) Integrating social into the comprehering social	censee shall for, diagnostic rvices prescribed by ssional staff, il work services spervised by a social ence working with s, responsible for: I work activities;				
		DER/SUPPLIER REPRESENTATIVE'S SIG	SNATURE	TITLE		(X6) DATE

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If continuation sheet 1 of 3

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PRINTED: 01/22/2019 FORM APPROVED

State of Washington

2018-11696

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
THE LEWIS OF COURSECTION		IDENTIFY BUTTON TO MODELL	A. BUILDING:					
007470		B. WING		C 10/01/2018				
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
NAVOS 2600 SOUTHWEST HOLDEN								
SEATTLE, WA 98126								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE		
L1110	Continued From page 1		L1110					
L1110	and (iii) Coordinatin community resource. This Washington Ad as evidenced by: Based on interview documents the host community social w (Patient #1) about the Failure to inform all working with the patient having a successful.  Findings include:  1. The hospital polic revised 05/2018 react Coordinator will attend their care givers/supaspects of the dischedited to the facil 07/06/2018 the counhold. The patient ditreatment facility after removed. The hospital policing the patient left again 07/06/2018.  There was docume inform the patient's provider and the patient a hospital did set up in the patient and the patient	g discharge with es; dministrative Code is not met and review of hospital pital failed to inform the orker working with a patient the discharge of the patient. The community resources tient about their discharge puts patients at risk for not discharge.  Exp titled "Discharge Planning", ad in part "The Social Services empt to involve patients and exportive person (s) in all harge planning process".  Frevealed the patient was ity on an involuntary hold. On the removed the involuntary emanded they leave the er the involuntary hold was bital tried to educate the ered for further treatment but not medical advice on that the hospital did outpatient psychiatric care tient's sister about the patient gainst medical advice. The medication for the patient to	L1110					
	pick up at an outpa	uent pnarmacy.						
	The hospital did no	t however notify the patient's						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
					(		
		007470	B. WING		10/0	1/2018	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  2600 SOUTHWEST HOLDEN							
		SEATTLE	, WA 98126				
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L1110	110 Continued From page 2		L1110				
	community social versions fact sheet about the 07/06/2018. There community social versions or	worker listed on their patient e discharge of the patient on was documentation that the worker called the hospital on ire about the patient. The resentative then informed the worker on 07/09/2018 the ischarged on 07/06/2018.  at 11:00 AM, Staff #1 was at 11:00 AM, Staff #1 was at 1 stated that they notified the ric provider and family about arge on 07/06/2018. Staff #1 d a phone call on 07/09/2018 y social worker inquiring about 1 then informed the worker the patient had been					
State Form 2	2567						

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